progressive dental™

it's personal

# VOLUNTARY

## Authorization to Share Information

I authorize the following individual(s):

_____(Name/Names)

_____(Relationship to Patient)

To:

____ receive appointment scheduling/reminders

____ leave a voicemail message

Home _____ Mobile _____ Work _____

____ schedule appointments

____ discuss financial issues on my behalf

____ pick up copies of my records

____ prescription pick up

____ pick up x-ray copies

____to bring _____ to the dentist for treatment, including x-rays or fluoride, as needed

____discuss treatment options/plan

____HealtheConnections **Relationship: _____
(step-parent, mother-father, health care proxy, power of attorney or legal guardians ONLY)

| _____ | _____ | _____ |
|---|---|---|
| Date | Patient Name (printed) | Parent/Patient Signature |

**I understand that I have the right to revoke this authorization at any time**


**ENDWELL**
565 Hooper Rd.
Endwell, NY 13760
P: 607.754.2273
F: 607.754.9526

**NORWICH**
101 S. Broad St.
Norwich, NY 13815
P: 607.334.8666
F: 607.334.6662

**MONTROSE**
57 Public Ave.
Montrose, PA 18801
P: 570.221.9200
F: 570.221.6640

**KIRKWOOD**
1113 US Rte. 11
Kirkwood, NY 13795
P: 607.722.5464
F: 607.775.1125

**BINGHAMTON**
51 Front St.
Binghamton, NY 13905
P: 607.724.7166
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